Written comments submitted to the Department of Health Care Services (DHCS)
Regarding the Transfer of the Drug Medi-Cal Program to DHCS, effective July 1, 2012
Comments received July 28 through August 2, 2011

Note: In some cases, DHCS has edited the responses to explain the acronym used by the writer, or to remove personally-identifying information. Specific references to the writer's organization have not been removed.

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San Mateo County Behavioral Health and Recover Services (BHRS) wishes to thank the Department of Health Care Services (DHCS), the Department of Mental Health and the Department of Alcohol and Drug Programs (ADP) for their efforts in guiding our systems through the integration of Medi-Cal programs into DHCS.

We would like to take this opportunity to frame certain principles, concerns and/or ideas that we hope will be considered as this process moves forward.

- BHRS advocates for the ongoing stakeholder participation not only during this transitional period, but afterward as well. It is an opportunity for us to have first-hand knowledge of anticipated changes as well as to influence future changes for the system.
- BHRS supports the idea that counselor certification needs to be streamlined into a single course that is accountable for the various certifications that are currently in existence. We would advocate moving alcohol and other drug certification to licensure in the future that would support higher standards of care and 3rd party billing.
- BHRS advocates moving site certification from ADP/DHCS to counties. This would be commensurate with how counties operate regarding site recertifications for the Department of Mental Health/DHCS.
- BHRS advocates moving negotiations of rates away for a state wide standard to county based rate negotiations because of the wide variation in cost of living/doing business.
- We support a deputy director responsible for both mental health and alcohol and other drug issues.
- Although outside the initial purview of transitioning Medi-Cal functions, we support that the final organizational structure for mental health and alcohol and drug programs be inclusive of all statewide responsibilities and not have a bifurcated structure separating Medi-Cal functions from the other functions.
- State responsibilities in addition to Medi-Cal should include but not be limited to formulation of state policy, Single State Agency responsibilities, outcome evaluations, needs assessment, epidemiological research.

During the initial calls there were a number of comments, pro and con whether mental health and alcohol and drug programs should be integrated into a single structure. In San Mateo County, we have been an integrated structure for the past 4 years and overall believe this reorganization has benefited our clients and community. Recognizing the complexities of those seeking our services we are now better positioned to respond in a meaningful way emphasizing total wellness and recovery. We recognize there is history that leads people to believe an integrated structure is not desirable. Our experience leads us to a different conclusion and we would encourage you to look for any and all possibilities where an integrated structure works best for persons with mental health, substance use and co-occurring disorders.

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As an "end user" and licensee of the Department of Alcohol and Drug Program (ADP) I have three years of close experience worth your time to consider in a restructure.

1) License analysts need to be closer to the facilities they are working with, and should be encouraged to create personal relationships with the program administrators. Much would be worked out quickly that takes months if that were the case. Local Southern California offices would be a way to do this. If there were a complaint people could be onsite in a day.

2) Electronic submission of all applications and forms would save a huge amount of ADP staff time and facility time tracking applications etc, It would also end incomplete submissions. The Commission on Accreditation of Rehabilitation Facilities (CARF) does this.

3) The CARF process is much more indepth and yet allows them to accept programs at varying levels of competency as long as they are improving. This model is way superior to the current model.

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County submission of the State Association of Addiction Services newsletter:

Language Matters. We hear this phrase often, usually when we are expressing our frustrations about someone else's choice of words, how words perpetuate the stigma that pervades our field, and the impact on the ability of our patients to seek and access treatment services. We blame society, "uneducated" individuals and policymakers, funding discrepancies, and the list goes on. While those issues play an important role in prolonging the stigma affecting our patients, as a field we can exacerbate the problem with our own language and choice of words. Think about the inherent "secrecy" of what we do "behind the walls of treatment centers". Unlike other health conditions, we identify our services by where they are performed: Outpatient and Residential. In this age of transformation and integration with primary care, it is time to talk about the actual services we provide and demystify the important work we are doing across the country. It is time to explain to our constituents and stakeholders that treatment plans are based on a diagnosis and, like all health conditions, are managed in a variety of settings: some in an outpatient setting; others need an inpatient/non-hospital setting. Treatment plans for substance use disorders, like other chronic disease treatment plans, generally have an "estimated" timeframe and stages of treatment.

But it goes beyond how we talk about our services. Let's look at our "everyday" language including how we talk to our patients. Everyone suffering from a chronic disease struggles with noncompliance and setbacks in their treatment plans, but they are not treated as failures. Relapse is the term our field uses to define noncompliance in treatment-which for many is interpreted as failure-"you blew it, so now you have to start over". For those unfamiliar with the chronicity of substance use disorders-funders, policy makers, and the general public-this means treatment failed. Our patients and providers are measured by failure rates. We talk about "dirty" drug screens and people "bombing out" of treatment. Can you imagine a person with diabetes being told they had a "dirty" lab report because their blood sugar levels were dangerously high?

Recently there has been intense debate around the usage of the term "behavioral health". For various reasons many practitioners do not like the term. We know that in a perfect world, we should not need an "umbrella phrase" for two distinct disorders/diseases/conditions/problems-mental illness and substance use disorders. Most other chronic conditions stand on their own by definition without being grouped together. In reality, most chronic diseases require some level of behavioral change to manage the condition. Therefore, why are we not referring to these diseases under the umbrella of

behavioral health? Regardless of one's personal viewpoint on the usage of the term "behavioral health", we cannot allow this debate to overshadow efforts to make an immediate day-to-day impact on the language in our own conversations with our staff and our patients. Consider the increased hope we could bring to individuals, families, and our communities if we began to change some of our own language and encourage our patients, former patients, and advocates to do the same.

We also cannot allow ourselves to become distracted from the critical issues and need for transformation facing our field. This is our opportunity as we integrate with primary care. We can move forward with language designed to give people respect, hope, and clarity about their disease. It is a low-cost strategy, but imagine the impact on the future.